SECTION VIII
MEDICAL STANDARDS & REPORTS

A. ASSESSMENT STANDARDS FOR MEDICAL

Medical Evaluation Standards

The medical component is a comprehensive assessment of the child's medical history prior to coming into care. **This information is used by DFCS staff, judges, CASA's and others to assure that the medical needs of children in foster care are addressed.** The medical standards should include, but are not limited to, the following:

Standard I

- Patient Name:
- Medical Record Number:
- Medicaid Number (if applicable):
    - Date of Visit:

Standard II

- Completed Georgia Department of Human Resources Immunization Form 3231
- Current Evaluation of the Child's Physical Health, including a current physical exam signed by a medical professional that covers the following areas:
    - Physical Exam
- Weight Height
- Blood Pressure Temperature
    - General, including skin, HEENT (head, eyes, ears, nose, throat), heart, lungs, abdomen, genitalia, lymphalus, musculoskeletal, and neurological
    - Vision Screen
    - Hearing Screen
    - Laboratory Data (when directed)
    - Radiological Studies (when directed)

Standard III

- Child's Medical History – Provider must collect all medical history for each child - from birth until the present date – regardless of the child's age and/or place of birth.
- Family Health History **(DHR Form # 419 Background Information on State Agency Child)**
    - Biological parents names, ages, current health status and their health histories
    - Siblings names, ages, current health status and their health histories
    - Extended family (grandparents, aunts, uncles, cousins, etc.) List significant health histories no need to list names or ages. List whether they are maternal or paternal relatives.

- Personal Health History
  - Biological mother – history of her pregnancy with this child, noting any problems with the pregnancy, delivery and any problems after birth that this child experienced
  - Developmental history – were all developmental milestones met as expected (e.g. walking, talking, toilet training, etc.)
  - Child's allergies – medication, food or environmental
  - Child's personal health history
  - Child's history of hospitalizations
  - Child's history of significant injuries
  - Child's sexual activity history
  - Child's substance use history
  - Immunizations – if not current, which immunization is due and when it is due. If current, when next immunization is due

Standard IV

- Impressions of child's current medical needs.
- Treatment Plan/Recommendations, if applicable.
- Referrals, if applicable.

The Medical Evaluation *must* include the following attachments in order to be complete:

- Physical Examination
- Medical Records
- DHR Form #419 Background Information for State Agency Child—Available online at www.gahsc.org or http://dfcs.dhr.georgia.gov . This form must be typed and completed in its entirety.
- DHR Form 3231 Certificate of Immunization

The provider is responsible for obtaining copies of all past and current medical records. An explanation must be provided on the reason any records were not obtained. Include documentation of all attempts to obtain records, as appropriate.

NOTE: ***When any routine and/or emergency treatment is identified during the course of the medical assessment, the county DFCS must be notified. Prior to any treatment being provided, a DFCS staff member must authorize by signature. Treatment examples include immunizations, ear tubes, minor surgery, etc.***

WHO CAN COMPLETE--Medical Evaluation

The provider can complete the medical evaluation form, which is a summary of the findings of the medical appointment with a licensed Medical Doctor. The provider, who may be Bachelor's level, must specifically list in the report the name, title, and date, of any licensed medical official from whom the information is obtained. A medical official may also complete the report.

The licensed medical professional completing the exam must sign the actual physical exam.

NOTE: CASE REVIEW *The case manager must continue to update each child's medical status every six months as part of the case review. This update must address any need identified in this assessment.*

B. MEDICAL ASSESSESSMENT REPORT

The title and format of the report is as follows and *must* include the following five (5) sections and all accompanying documentation.

Medical Assessment Report

I. **Identifying Data**

- Patient Name:
- Medical Record Number:
- Medicaid Number (if applicable):
- Date of Visit:

II. **Current Evaluation**

- Physical Exam ***(This portion of the report must be completed and signed by the licensed professional completing the exam.)***
    - Height
    - Weight
    - Blood Pressure
    - Temperature
    - General
    - Skin
    - HEENT (head, eyes, ears, nose, throat)
    - Heart
    - Lungs
    - Abdomen
    - Genitalia
    - Lymphalus
    - Musculoskeletal
    - Neurological
    - Vision Screen
    - Hearing Screen
    - Laboratory Data
    - Radiological Studies
    - Summary statement regarding the current overall health/medical status of the child.

III. **Medical History**

- Child's History of Present Illness
- DHR Form #3231 Certificate of Immunization
- Family Health History (DHR Form # 419)
    - Biological parents names, ages, current health status and their health histories
    - Siblings names, ages, current health status and their health histories

    - Extended family (grandparents, aunts, uncles, cousins, etc.) List significant health histories; no need to list names or ages. List whether they are maternal or paternal relatives
  - Personal Health History
- Biological mother – history of her pregnancy with this child, noting any problems with the pregnancy, delivery and any problems after birth that this child experienced
- Developmental history – were all developmental milestones met as expected (e.g. walking, talking, toilet training, etc.)
- Child's allergies – medication, food or environmental
- Child's personal health history
- Child's history of hospitalizations
- Child's history of significant injuries
- Child's sexual activity history
- Child's substance use history
- Any significant problems with daily living activities – eating, sleeping, elimination, etc.
- Child's disabilities and/or mental health issues

- History of Illness of this child

☐ Allergies	☐ Asthma	☐ Chicken Pox
☐ Convulsive Disorders	☐ Earache or Discharge	☐ Frequent Colds
☐ Frequent Urine	☐ German Measles	☐ Hookworm
☐ Measles	☐ Meningitis	☐ Mumps
☐ Pneumonia	☐ Rheumatic Fever	☐ Rickets
☐ Scarlet Fever	☐ Tonsillitis	☐ Tuberculosis
☐ Whooping Cough	☐ Other (specify) _____	

Complications:
Hospitalization:
Handicapping Conditions:
Allergies:

List all medications child is currently taking.

- Health Status

Last Physical or EPSDT	Date	Results
Hearing/vision	Date	Results
Other (*Specify*)	Date	Results

- List all Health Care Providers *(including immunizations)* and Addresses

- Immunizations (Attach Immunization Certificates) - Give dates of each and when next immunization is due.
  - ☐ DPT
  - ☐ Polio
  - ☐ Rubella
  - ☐ Measles
  - ☐ Other *(specify)*
  - ☐ Other *(specify)*

IV. **Summary and Recommendations**

- Impressions of the child's current medical needs
- Treatment Plan/Recommendations, if applicable
- Referrals, if applicable

V. **Name, Signature of Licensed Professional and Date Completed**

The provider can complete the medical evaluation form, which is a summary of the findings of the medical appointment with a licensed Medical Doctor. The provider who may be Bachelor's level must specifically list in the report the name, title, and date, of any licensed medical official from which the information is obtained. A medical official may also complete the report.

- Print Name
- Signature
- Job Title
- Date

REMINDER:

The Medical Evaluation *must* include the following attachments in order to be complete:

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